STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 16,414
	)	
Appeal of	)	
	)	

INTRODUCTION

The petitioner appeals the decision by the Department of PATH denying his wife's application for VHAP benefits. The issue is whether the Department's regulation imposing a 12-month waiting period for VHAP after the petitioners' private insurer ceased doing business in Vermont is consistent with federal Medicaid law. The facts necessary to reach this issue are not in dispute.

FINDINGS OF FACT

1. The petitioner and his wife live together and are in their sixties. Their sole income is the petitioner's Social Security benefits of $1,125. Since March 2000 the petitioner has received Medicare and VHAP-Pharmacy benefits.

2. Until 1995, the petitioner and his wife had health insurance through the petitioner's employer. This coverage ended when the petitioner became disabled and stopped working.

3. From October 1996 through February 1999 the petitioners purchased private health insurance as a couple through CHP/Kaiser Permanente. The costs of maintaining that private coverage continually escalated. Between September 1998 and February 2000 their monthly premium was $439.58. The petitioner's wife is a diabetic. In addition to customary household expenses the petitioner's wife has monthly pharmacy expenses of about $280.

4. Effective March 1, 2000, Kaiser discontinued its coverage of Vermont residents. When notified that this coverage was ending the petitioners applied for VHAP. At that time they had depleted their savings (mostly on insurance premiums) and they maintain that they could no longer afford to obtain coverage through an alternative private provider.

5. It is not disputed that because the petitioner had become eligible for Medicare at that time he was not eligible for VHAP. In a decision dated February 28, 2000 the Department found the petitioner eligible for VHAP-Pharmacy[1] (to supplement his Medicare) and determined that his wife was financially eligible for VHAP. However, the Department found the petitioner's wife ineligible for VHAP until March 1, 2001 due to a 12-month waiting period imposed because the

petitioners had not lost their private insurance due to circumstances specifically set forth in the program regulations (see infra).

ORDER

The Department's decision imposing a twelve-month waiting period for VHAP eligibility for the petitioner's wife is reversed.

REASONS

VHAP (the Vermont Health Access Plan) was created for the purpose of "providing expanded access to health care benefits for uninsured low-income Vermonters." W.A.M. 4000. The state regulation defining "uninsured" includes the following:

> Uninsured or Underinsured
>
> An individual meets this requirement if he/she does not qualify for Medicare, does not have other insurance that includes both hospital and physician services, and did not have such insurance within the 12 months prior to the month of application. The requirement that the applicant not have had such insurance during this 12-month period is waived if the department has agreed to pay all costs of insurance because it is found it is cost-effective to do so or if the individual lost access to employer-sponsored insurance during this period because of:
>
> (a) loss of employment, or

[1] The VHAP-Pharmacy program does not contain any waiting periods.

(b) death or divorce, or

(c) loss of eligibility for coverage as a dependent under a policy held by the individual's parent(s).

. . .

WAM § 4001.2

The petitioners in this matter argue that the above provision is inconsistent with federal Medicaid law governing the conditions under which Vermont can administer the VHAP program pursuant to a "waiver" granted to it by the United States Department of Health and Human Services (HHS). The Board agrees.

Both parties acknowledge that the VHAP program was created, and receives the bulk of its funding, pursuant to a waiver granted by HHS under federal Medicaid law, 42 U.S.C. § 1315. Under the terms of this statute the Secretary of HHS "may waive compliance with any (state plan) requirements. . .to the extent and for the period he (sic) finds necessary to enable such State or States to carry out such project. . ." The parties further agree that in February 1995, the Vermont Agency of Human Services applied to HHS for such a waiver to implement and fund its VHAP program, and that HHS subsequently granted Vermont a waiver according to the terms of the Agency's application.

The Department does not appear to dispute that in devising regulations and policies governing the VHAP program it is bound by federal Medicaid law except as expressly provided by the terms of its waiver granted by HHS. See Boulet v. Celluci, 107 F.Supp.2d 61 (D.Mass. July 14, 2000); Makin v. Hawaii, 114 F.Supp.2d 1017 (D.Hawaii, November 26, 1999). The **Vermont VHAP Waiver Initiative** dated February 23, 1995 includes a section governing "Eligibility Standards and Covered Populations" (pp. 8-15). The only provision cited by the Department in that section (or anywhere else in the waiver) governing one-year waiting periods is the following (at p. 14):

> Coverage will be limited to persons within defined income limits who are uninsured at the time they apply for benefits under the *Vermont Health Access Plan.* Applicants who voluntarily drop other health insurance coverage will have to wait one year (from the effective date of loss of other coverage) to become eligible for the *Vermont Health Access Plan.*

Thus, it appears that the only language concerning a waiting period set forth in the waiver itself applies only to applicants who "voluntarily drop coverage" before applying for VHAP. Inasmuch as neither party maintains that there is any other provision in the Medicaid regulations imposing a waiting period for coverage, the issue in this case is whether the provisions in WAM § 4001.2, supra, constitute a definition of

"uninsured" that is consistent with the above terms of the Vermont waiver.

There is no dispute that the petitioners' private insurer ceased doing business in Vermont as of March 2000. The petitioners allege that they were unable to afford any alternative private insurance that may have been available to replace their coverage under Kaiser. Therefore, they argue that they cannot be found to have "voluntarily" dropped their coverage within the plain meaning of the Department's federal VHAP waiver. The Department maintains that the provisions in WAM § 4001.2, supra, are consistent with the State's federal waiver. However, based on the wording of § 4001.2 it is clear that the Department never really considers whether VHAP applicants have "voluntarily drop(ped) other health insurance coverage". Its inquiry is limited solely to the three circumstances set forth in the regulation—none of which even addresses the affordability to an applicant of obtaining other insurance.

Indeed, WAM § 4001.2 imposes a waiting period on all applicants who had private insurance except those who lost their insurance as a result of loss of employment, death or divorce, or loss of dependent status—regardless of whether the loss of coverage was otherwise "voluntary". The petitioners,

who fully meet the income guidelines for eligibility, and whose private insurance carrier left the state, maintain that their loss of coverage was at least as "involuntary" as the situations set forth in the regulation. To the extent that § 4001.2 operates to arbitrarily disqualify applicants like the petitioners without any inquiry into whether their loss of private insurance was otherwise "voluntary", it must be concluded that the regulation impermissibly conflicts with the State VHAP waiver and, thus, with federal Medicaid law.

The Department maintains that WAM § 4001.2 was adopted in response to the direction of the legislative health access committee, which appears to have been established as a "transitional provision" in the 1995 Vermont legislature (Public Act No. 14) following federal waiver approval of the VHAP program. According to the Department, a concern of that committee was that private employers would drop health insurance as an employee benefit if their employees could immediately qualify for VHAP, and that this would place a strain on available VHAP funding. The Department maintains that the committee directed it to address this concern by implementing the provisions in § 4001.2 imposing a twelve-

month waiting period unless the loss of employer insurance coverage is accompanied by a loss of employment.[2]

The Department further alleges that in last year's session the legislature specifically considered but failed to adopt a statutory provision allowing coverage for individuals, like the petitioners herein, who lose coverage when a private insurer like Kaiser Permanente ceases doing business in Vermont. Thus, the Department argues, § 4001.2 is dictated by and consistent with past and current state legislative policy.

From a legal standpoint, however, the problem is that no such policy appears anywhere in the Vermont waiver from HHS or elsewhere in the Medicaid statutes. As noted above, the Vermont waiver imposes a waiting period only on those applicants who "voluntarily" drop private insurance. The Department does not even argue that a unilateral decision by an employer to drop an employee's health benefits constitutes a "voluntary" action on the part of that employee. In this respect, the Department's stated policy of discouraging employers from discontinuing insurance coverage for their

[2] It is not clear why the only other two qualifying circumstances—i.e., losses of coverage caused by death or divorce or by the loss of dependent status—made their way into the regulation.

employees, though, perhaps, otherwise rational, is not only inconsistent with the waiver, it flies in the face of it.

The Department further argues, however, that its regulation is nonetheless consistent with the State's underlying purpose (as stated in the waiver) that VHAP "meet the needs of the greatest number of uninsured lower income individuals at a level of fiscal commitment which it can afford today and into the future." Again, however, this argument completely ignores the express provision in the waiver that waiting periods are to be imposed only in cases of a "voluntary" loss of private health coverage. In making determinations of eligibility under VHAP the Department cannot ignore the plain language of its waiver simply to meet the challenge, however daunting, of providing widespread medical coverage within fiscal limitations.

The legal issues in this matter are in most respects indistinguishable from those in Dutton v. Department of Social Welfare, 168 Vt. 281 (1998). In that case the Vermont Supreme Court, in reversing a decision of this Board (which was based on a Recommendation by this hearing officer), held that a state definition of a "household" under the fuel program was invalid because it conflicted with the definition contained in the federal statute. In that case the Department also claimed

that it was bound by a definition of coverage dictated by the Vermont legislature, which, in turn, was purportedly responding to concerns over the program's fiscal viability. In summarily disposing of this argument the Court noted ". . .we fail to see how it is significant. . .If the state regulations are in conflict with federal law, the fact that they are also consistent with state law would not remedy this problem." Id. (footnote at p. 285).

In this case the federal law, as expressed in the Medicaid statutes and the terms of the Vermont waiver from HHS, is clear. If an applicant is financially eligible for VHAP, a twelve-month waiting period can be imposed only when an applicant "voluntarily" drops other health care coverage. Therefore, to the extent that WAM § 4001.2 imposes conditions to eligibility that plainly conflict with the state's Medicaid Waiver, it cannot be upheld.

This leaves the question of "appropriate relief".[3] As noted above, the petitioners in this matter lost their private insurance coverage when their insurer, Kaiser Permanente, ceased doing business in Vermont. The petitioners further allege that they could not afford to obtain other coverage; but based on the Department's current policy under § 4001.2

the Board need not reach this factual issue. It is concluded that the petitioners have set forth sufficient undisputed facts to show that they are in a situation factually and legally indistinguishable from those who are presently eligible for VHAP under §4001.2.

Under § 4001.2 the Department makes no inquiry into whether an applicant who loses employer-sponsored health insurance due to loss of employment, death or divorce, or loss of dependant status has the means to obtain other insurance.[4] In a case such as this, in which an applicant's private insurer unilaterally terminates his or her coverage, it must be concluded that the applicant's circumstances in losing coverage are at least as compelling as those now permitted under § 4001.2. Thus, as a matter of fairness and equal treatment, it must be concluded that the petitioner's wife has demonstrated at least the same level of "involuntariness" as that currently required by the regulations. See Brisson v. Department of Social Welfare, 167 Vt. 148, 152 (1997). Therefore, the Department's decision in this matter imposing a

[3] See 3 V.S.A. § 3091(d).

[4] Under the Department's regulations an applicant who loses coverage under these circumstances does not have to elect COBRA coverage, even if such coverage would cost the same or less than the applicant was paying before he or she lost employer-based coverage. It even appears that an applicant who voluntarily quits a job that had health benefits, or who voluntarily

twelve-month waiting period on the petitioner's wife for VHAP coverage is reversed.

# # #

switches to a job with no health coverage, can qualify for VHAP with no further inquiry.